Red Homes Healthcare Grantham Limited

Red Court Care Community

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
Red Court Care Community is a residential care home providing personal and nursing care to people both under and over 65, including some living with dementia. The home can support up to 49 people. At the time of our inspection there were 41 people living in the home, including two people who were admitted to the home on the day of the inspection.

People's experience of using this service and what we found
Although the provider claimed they placed people at the heart of the service, relatives and staff expressed concerns about staffing at weekends and nights, and at times during the day.

At the time of our inspection there was not a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated regulations about how the service is run. The new manager, who had only been there three weeks, had proposed shift changes to cover the identified busier times of day.

The service was not well managed. There had been a lack of effective oversight of the service by the provider. The lack of robust, effective quality assurance meant people were at risk of receiving poor quality care.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection
The last rating for this service was requires improvement (published 29 August 2019).

At this inspection we found improvements had not been made and the provider was now in breach of regulations.

Why we inspected
We had received concerns about the lack of robust systems and processes to ensure consistent supplies of PPE, staffing, food and laundry supplies, particularly through the Covid-19 pandemic.
A focused inspection was undertaken to specifically check whether sufficient improvements in the safety of the service and people's care had been achieved and to assess whether the manager and provider now had sufficient oversight of the service. At this inspection we continued to have concerns about the safety of the service and its leadership.

We reviewed the information we held about the service. No areas of concern were identified in the other key questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those

key questions were used in calculating the overall rating at this inspection.

We have found evidence the provider needs to make improvements. Please see the Safe and Well-Led sections of this full report.

You can see what action we have asked the provider to take at the end of this full report.

The overall rating for the service has not changed from requires improvement. This is based on the findings at this inspection.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Red Court Community Care on our website at www.cqc.org.uk.

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection.

We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified breaches in relation to Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3) Regulation 17 (Good Governance) and a Breach of Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3) Regulation 18 (Staffing) at this inspection.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
We will request an action plan for the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Details are in our safe findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-Led findings below.

Red Court Care Community

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

Inspection team
The inspection team consisted of two Inspectors.

Service and service type
Red Court Care Community is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

At the time of our inspection there was not a registered manager, but an acting manager who had been there three weeks. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated regulations about how the service is run.

Notice of inspection
We gave the service ten minutes notice of the inspection. This was because we needed to check whether anyone had Covid-19 at the service and to establish the Registered Person's PPE protocols so we were able to follow this guidance.

What we did before inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. We used the information the provider sent us in the provider information return. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information

helps support our inspections. We used all of this information to plan our inspection.

During the inspection
We spoke with six members of staff including the manager, the deputy manager, a nurse, a senior care worker, a laundry worker and the chef.

We reviewed a range of records. This included eight people's care records. A variety of records relating to the day to day staffing and management of the service.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We spoke to 5 further members of staff and five relatives by telephone

Requires Improvement

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last inspection this key question was rated as requires improvement. At this inspection this key question has now remained the same.

This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk people could be harmed.

Staffing and recruitment

● Relatives told us there were not always enough staff on duty to meet people's needs. One example was given of a person who had been forgotten about at mealtimes, as they didn't always feel hungry, and needed the prompt of food being offered and brought to them. They had reported this on several occasions to their relatives. People had also been told staff were too busy to get them up in the mornings. They had told their relatives they felt unwanted.

● The service's dependency tool, used to calculate staffing levels, was not fit for purpose. It did not accurately show how much time staff needed to care for people according to their assessed level of need. The manager was aware of this issue and was addressing it. Relatives told us that lack of staff resulted in people not being able to have their hair washed, even weekly, which at a time when hairdressers could not go into the home people found particularly upsetting.

● Staffing levels, determined by the provider, were not always met. Staff told us the actual rota rarely reflected the actual amount of staff on duty. Short notice staff absences were often not covered, as Agency staff were not always available.

● The service did not regularly review its staffing levels and skills mix to make sure staff were able to respond to and meet people's changing needs.

● Systems and processes to cover staff absences were not robust enough to ensure there were always enough staff on duty to meet people's needs.

● Following our inspection, the manager sent us an updated dependency tool which showed staffing levels needed to be increased to ensure people were kept safe and their needs were met. The manager was recruiting to address this issue. In the interim agency staff were to be used ,with a preferred provider.

We recommend the provider reviews staffing levels and puts measures in place to ensure that people always receive timely and safe care and treatment.

The provider failed to ensure sufficient numbers of staff were deployed to meet people's needs. This was a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3)

Systems and processes to safeguard people from the risk of abuse

● Improvements were needed to the way staff managed people's money. People did not always have immediate access to their own money. The payment process for services provided in-house such as

hairdressing and chiropody was unclear. This could put people at risk of financial abuse. The manager accepted this and sent us an updated plan and recording mechanism which ensure more robust records and improve people's access to their money.
● Staff knew about the service's safeguarding policy. They know what to do if they had concerns about safety and felt comfortable raising concerns.
● There were arrangements for communicating with people who had difficulty speaking.
● There was a range of activities on offer. Care records were being updated and personalised
● Appropriate employment checks had been carried out to ensure staff were suitable to work with vulnerable people.

Assessing risk, safety monitoring and management
● One person was unable to leave their room independently as they were unable to open the door. This meant their movements were restricted. Their risk assessment did not consider or resolve the issue, for example, by installing a push-button option so the person could open their door independently. Relatives told us that this made the person feel isolated. This was raised with the manager who said she would look into this.

Using medicines safely
● Staff managed medicines consistently and safely. Medicines were stored correctly and disposed of safely. Staff kept accurate medicines records.
● Access to appropriate clinical equipment had improved with the recent re-alignment of GP surgery provision in the area, as the staff were now able to easily and safely access clinical items which had been problematic to access at the start of the pandemic.

Preventing and controlling infection
● Staff did not consistently have the resources they needed to prevent and control infections in the service. Staff experienced near shortages of supplies, such as Personal Protective Equipment (PPE) and laundry detergent as the provider had not paid supply invoices in a timely manner. On two occasions staff had been unable to undertake laundry tasks due to lack of resources. This meant soiled laundry was not managed safely, increasing the risk of infections for people and staff.
● The provider was not able to provide robust assurance that processes put in place mitigated further risks of shortfalls in resources. Following our inspection, there was a further incident on 18 August 2020 resulting in staff being unable to complete laundry.
● On the day of inspection staff were seen to be wearing PPE appropriately.
An action plan and new documentation information received post inspection indicates the issues identified have had more robust processes put in place and we will assure ourselves of sustainability at the next inspection.

Learning lessons when things go wrong
● When things went wrong, reviews and investigations were not always sufficiently thorough and did not include all relevant people.
● The provider did not always make improvements when things went wrong or learn from incidents. For example, the manager had requested care interactions were covertly monitored to support a review of people's placement so the provider could issue notice. The local authority was in the process of investigating people's complaints as this had been identified as a restrictive practice.

Inadequate

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as Requires Improvement. At this inspection this key question has deteriorated to Inadequate.

This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- There was a lack of consistency in how the service was managed and led. This meant there was no registered manager in post
- A manager from another home owned by the provider had recently started at the home and was in the process of registering as registered manager for this home. The current manager had been there less than a month and they were the sixth manager in post since the provider took over the service in 2017. This had been a negative effect on people, relatives and staff.
- Systems and processes did not effectively assess, monitor or mitigate risks relating to people's health, welfare and safety as the dependency tool used to calculate staffing levels was not fit for purpose. This was because it did not accurately assess people's individual dependency needs. The manager wished to implement a new dependency tool, which was presented at the inspection.
- Systems and processes for the supply of resources such as agency nurses, groceries, personal protective equipment (gloves, aprons and masks), and cleaning products were disorganised and unreliable. This put people at risk of inadequate staffing levels and food. Staff did not always have access to the personal protective equipment and cleaning products they needed. For example, laundry supplies were unavailable from the supplier on 10 June, and 15 July 2020. On each occasion supplies had to be brought from the sister home 26 miles away.
- We found that issues identified in our report following our December 2018 inspection were still a concern and had not been robustly addressed. The provider had still not put in place effective arrangements were in place to ensure there were sufficient experienced staff so that people were cared for safely. This was a breach of Regulation 18 which is dealt with elsewhere in this report. Visiting professionals, we spoke with also expressed concern about the lack of staffing and support provided by the provider.

The failure to ensure effective governance and leadership was a breach in relation to Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3) Regulation 17 (Good Governance)

An action plan and new documentation information received post inspection indicates the issues identified have had more robust processes put in place and we will assure ourselves of sustainability at the next inspection.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

● Some staff told us they did not feel listened to, respected, valued or supported, they told us they had been told if they didn't like things as they now were they could leave. This meant they didn't feel able to raise concerns either within or outside the home. This had impacted on carers feeling able to get support throughout the pandemic. This showed the provider did not promote a culture that was open and inclusive.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

● Openness and transparency was lacking. Staff told us they had raised their concerns about the staffing issues, and they were concerned that people were put at risk due to the reliance on Agency staff. We saw and heard evidence that there had been at least one occasion there were insufficient numbers of staff deployed to keep people safe during the night.

Continuous learning and improving care

● The new manager was already working to an action plan but had not been in post long enough to be able to demonstrate the impact.

● There were new processes in place to carry out quality checks, and identify areas for improvement, but they were new and yet to be embedded.

Working in partnership with others

● The service was starting to work well with the new GP alignment practice in the area and this was showing a positive effect on communication between the home and the wider health professionals.